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Family Motivation to Change®:

A Major Factor In Engaging Alcoholics In Treatment

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Abstract

Family Motivation to Change can best be understood as the combined forces operating within a family guiding it towards maintaining survival in the face of serious threat, and towards healing when threat is removed. Exploring what happens to families during major disaster allowed the authors to step back into the grief that initiates the problem. The authors discovered that the force driving a family towards health is the same force that drove them to the initial adaptive behavior where a family member becomes addicted in an attempt to keep the family close, preventing them from feeling the pain of intense loss and sorrow. Once this has happened, the driving force of health and healing, “Family Motivation to Change,” pushes, frees, or allows a member of the family, a natural change agent or Family Link to lead the family out of grief and addiction into health and recovery.

Key words

Family motivation; motivation to change; breaking the intergenerational cycle; alcoholism in the family; addiction; concerned other; intervention; ARISE; invitational intervention; Transitional Family Therapy; treatment engagement; transitional pathway; transitional conflict; Family Link

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Introduction

The family is the core unit of social relationships across all cultures. It is difficult to conceive of a culture surviving without the family. “The family is the natural context for both growth and healing--The family is the natural group which over time has evolved patterns of interacting. These patterns make up the family structure, which governs the functioning of family members, delineating their range of behavior and facilitating their interaction. A viable form of family structure is needed to perform the family’s essential tasks of supporting individuation while providing a sense of belonging” (Minuchin & Fishman, 1981, page 112). For the purpose of this paper, family is defined as a domestic group of people, or a number of domestic groups, linked through descent (demonstrated or stipulated) from a common ancestor, marriage, or other committed coupling, legal or informal adoption, or through the choice to become kin to each other. It includes the extended intergenerational family network, by blood or choice, in its broadest sense. Stressors, such as untimely death, massive or unpredictable loss, cultural conflict, and unresolved grief, result in families getting off track from healthy functioning. In such situations, individual family members can become “symptomatic” and develop behaviors that are initially designed to protect the family from pain, keep families close, and help rebuild homeostatic functioning (Haley, 1980; Stanton, 1977). These adaptive behaviors later develop into destructive patterns that can be transmitted across generations, ultimately preventing the family from moving from one family life cycle stage to the next stage (Landau, 1982; Landau-Stanton, 1985; Landau, Garrett, et al., 2000). Alcoholism is known to be a risk associated with an increase in family stressors (Johnson, Richter, McLellan, & Kleber, 2002).

Studies of Jewish holocaust survivor families demonstrate how alcoholism results from disruption of family connectedness, family continuity and cultural transition. The rate of alcoholism in Jewish families prior to World War II was extremely low, while research after World War II shows alcoholism rates in subsequent generations of Jewish families that approach those in the population at large. This increase relates to the disruption in traditional family functioning, forced migration, conflicts in cultural transition and the significant number of holocaust related deaths. (McGoldrick, Pearce and Giordano, 1982; Perel & Saul, 1989). Addiction in refugee populations is approximately 30% higher than the general population (Landau & Saul, 2004; Landau, 2005). If increased family stressors and unresolved transitional conflict are related to the development of symptomatic behavior in individual family members, then a decrease in stressors and resolution of transitional conflict is likely to result in the return of competent family functioning and healthier individual functioning.

The concept, “Family Motivation to Change,” presented in this paper, is based on the belief in the inherent competence and resilience of families. Alcoholism affects the family, and the family can positively affect recovery from alcoholism. Applying engagement and treatment methods for alcoholism based on this concept has been shown to improve treatment engagement, retention and outcome (Landau et al., 2004; Stanton & Shadish, 1998; Galanter, 1993). In addition to describing the concept, one of its practical applications for engaging resistant alcoholics in treatment will be presented in illustration.

The Family in Transition

Family Transitions

Transitional Family Therapy, the theoretical model on which our thinking is based, views the family as intrinsically competent, resilient and healthy and the family can be a resource for individuals in times of stress (Landau-Stanton, 1986; Watson & McDaniel, 1998; Walsh, 2003).

Our goal is to empower families to identify resources that they can use to cope with life's challenges, including the important life cycle transitions or losses that confront them. Although change is a natural part of living, experiencing multiple transitions, typically 3 or more (even normal, predictable life-cycle events such as the birth of a baby, promotion of a breadwinner, or the death of an elder) within a short period of time can create stress (Boss, 2001; Figley & McCubbin, 1983; Garmezy & Rutter, 1983). It is during these times that families are likely to develop problems, exhibit symptoms, and need help. Accordingly, it is vital that therapists using Transitional Family Therapy approach individuals and families with the attitude that, given a set of tools and some brief therapeutic assistance, families are capable of designing effective solutions to their problems, rather than viewing them as "broken" and in need of lifelong hand-holding. This guiding principle forms the basis of "Family Motivation to Change."

We often refer to Transitional Family Therapy as a form of "brief intermittent therapy," since families work through a crisis, develop their own set of tools, learn to access their inherent resources, and develop a sense of competence, hope and faith in themselves. For the most part, this therapy enables them to deal with future challenges and life cycle transitions unassisted. However, there may be times when there have been a number of life cycle and other stressors in a short period of time, where a few family therapy sessions are once again helpful.

Transitional Conflict

In times of stress or upheaval, the response from molecular to interpersonal to societal level, is to disconnect or dissociate. During such times, the Transitional Pathway—the fragile but essential line connecting individuals' and families' past, present and future—can easily become disrupted and asynchrony between the rate and direction with which individual family members adjust to change results in "Transitional Conflict" (Landau-Stanton, 1990). The stress of transitional conflict, especially when upheaval is rapid or traumatic, such as when the natural

direction of the life cycle is disrupted (e.g., untimely death like the death of an infant or child), or when resources are insufficient to balance the stresses (Hobfoll, 1989; Landau-Stanton & Clements, 1993) results in one or more members of the family becoming symptomatic.

Transitional Family Therapy with adolescent alcohol abusers has been tested by Stanton using the *Transitional Family Therapy Treatment Manual for Use With Adolescent Alcohol Abuse and Dependence* (National Institute of Alcohol Abuse and Alcoholism, 1999; Landau & Garrett, 1998). The data from this study are currently in analysis.

Symptom as Adaptation: Intergenerational Transmission

Left unaddressed, transitional conflict arising from migration, rapid or unpredictable transitions, traumatic loss, and grief can lead to a variety of symptoms, including addiction, depression and suicidality, violence, post-traumatic stress, and risk-taking behaviors, including those that can lead to HIV/AIDS (Landau & Saul, 2004). For example, within one year after September 11th, 2001, there was a 31% increase in the rate of substance abuse and addiction in New York City and its immediate surroundings—approximating the addiction statistics of uprooted persons around the world (Johnson, Richter, McLellan & Kleber, 2002). At times of overwhelming grief, families find ways of compensating and staying close together, often without conscious intent. Frequently, one member of the family will begin to use alcohol or other substances, or exhibit other symptoms that serve the dual purpose of drawing the family's attention away from the grief and holding the family together to deal with the problems arising from the new problem behavior or symptoms. The result is that the family is unable to process their current transitions, remaining locked in the transitional conflict of the moment. Since this maintains their closeness, it helps to assuage the grief and reduce the pain. When the symptoms or alcohol use are reduced, the pain and grief return, reinforcing the need for the problem. The addiction cycle is set, and is often transmitted across generations until the family grieving is

resolved, the symptom has become redundant, and healing can occur (Landau, 1979, Landau, 1981; Landau & Stanton, 1990; Landau, Garrett, et al., 2000; Landau, 2004a; Landau, 2004b).

Family Resilience

When people are able to access past resilience by being in touch with their history, they can understand that the intergenerational history of alcoholism described above might well have been started as an attempt at adaptation to loss in order to protect the family from pain and to keep them together until their grief was resolved. This knowledge frees the current generation from guilt, shame, and the inevitability of a future locked into alcoholism. Hope is returned. They are able to reconnect their transitional pathways, knowing where they came from and where they are now. This allows them to recognize and utilize biological, psychological, social, and spiritual resources, making informed choices about what to keep from their past to draw on for the future and what to leave behind (Landau-Stanton & Clements, 1993). This is particularly relevant for practitioners dealing with alcoholism because the prevalent notion in the field is that patients struggling with recovery from alcoholism should be kept at a distance from their families. In exploring how families access and maintain resilience and competence across time, we examined the impact of attachment or connectedness to family and culture of origin in a series of women. The more connected they were, the less likely they were to take sexual risks. One of the measures was their knowledge of family stories, and even if those were problematic, it was still more protective than knowing no stories at all (Landau, Cole, Tuttle, Clements, & Stanton, 2000; Tuttle, Landau, Stanton, King, & Frodi, 2004). Other research indicates that strong social relationships and support can provide health protection, and that lacking these connections can compromise health (House, Landis, & Umberson, 1988; Rankin & Fukuoka, 2003).

Family Connectedness.

The connection of the alcoholic to his/her family of origin is well documented (Stanton & Shadish, 1997). In fact, contrary to the common perception in the field, alcoholics care about their families and their families care about them. They remain very closely connected; in fact more closely connected than the general population. Averaging several studies, it appears that 9% of nonaddicts tend to call their families daily while addicted persons maintain daily contact with their families at a rate of approximately 57% in the US, 62% in England, 80% in Thailand and Italy, and 67% in Puerto Rico (Perzel & Lamon, 1979; Vaillant, 1995).

Individual Motivation to Change

Prochaska and DiClemente's Stages of Change model represents six individual motivational stages that explain how an individual progresses from preparing for change to eventually taking action to change addictive behaviors and move into long-term recovery (Prochaska, DiClemente, & Norcross, 1992). This paper focuses on how Family Motivation to Change addresses the goal of getting a resistant alcoholic into treatment. *Family Motivation to Change* positively influences all six of the Stages of Change. We will, however, discuss only the first two stages of Prochaska and DiClemente's Individual Motivation to change, because these are the two on which Family Motivation to Change primarily impacts.

Stages of Change starts with Pre-contemplation, where the individual is too unwilling, unknowing or unable to acknowledge that the drinking problem requires a change in drinking behavior. Contemplation, the next stage, is where the individual recognizes that the drinking is a problem and may require a change in behavior, but is not ready to take action. These two stages are marked by denial of a problem, resistance to getting help and significant ambivalence. It is at these initial stages that we believe our Invitational Intervention method for engaging alcoholics in treatment, ARISE, A Relational Intervention Sequence for Engagement operates (Garrett,

Landau-Stanton, Stanton, Stellato-Kabat, & Stellato-Kabat, 1997; Garrett et al., 1998; Garrett et al., 1999; Garrett & Landau, 1999; Landau, Garrett, et al., 2000).

Family Motivation to Change

Background and Philosophy

Family Motivation to Change can best be understood as the combined forces operating within a family that guide it towards maintaining survival in the face of serious threat, and health and sustained functioning when threat is removed. The authors have studied this process as it pertains to not only getting a loved one into alcoholism treatment, but also to enhance health-seeking, or reduce risk-taking, behaviors, in such areas as: sexual risk-taking for HIV-AIDS prevention; domestic violence; treatment and medication compliance for chronic and life threatening illness. We have termed this survival drive of the family “Family Motivation to Change” (Landau et al., 2004).

Exploring what happened to families during major disaster, allowed the authors to take a step back into the grief that initiated the problem (Landau & Garrett, 2005). We discovered that the force that drives a family towards health is the same force that drove them to the initial adaptive behavior described above where a family member becomes addicted in an attempt to keep the family close and to prevent them from feeling the pain of intense loss and sorrow. Eventually, the focus on the problems caused by the individual’s alcoholism slows the process of successfully completing normal family life cycle transitions until the grief is resolved.

Once this has happened, the driving force of health and healing, “Family Motivation to Change,” pushes, frees, or allows a member of the family, a natural change agent or Family Link to lead the family out of grief and addiction and into health and recovery (Landau, 1979, Landau, 1982; Landau-Stanton & Clements, 1993; Landau, 2004a).

Operational Process

The following section addresses how Family Motivation to Change is operationalized by families to get a loved one into alcoholism treatment. The process is typically activated by one member of the family who has the interest, motivation, strength, credibility and cross-generational knowledge of the family to act as a “Family Link” in starting and coordinating the process. Below are some of the key elements that operate on conscious and sub-conscious levels.

First Protecting and Then Healing the Family.

The initial protection of the family starts unconsciously as one member of the family is drawn to offer him/herself as the sacrifice to serve as the diversion for a loved one from acute pain and grief, as discussed above. The motivating force functions to prevent the loved one from suffering grief to the extent that s/he might choose to join those lost in death. Each time that the alcoholic starts to succeed at a job, at leaving home, or at any other life cycle transition, the depression, grief, or overwhelming loss of the person s/he was protecting is likely to return. At this point, the alcoholic is highly likely to relapse, to save the loved one once again. It is only once the grief is resolved throughout the extended family that the alcoholic can succeed to traverse the life cycle transition with success and move into recovery for the long-term. At this stage, the same protective driving Family Motivation to Change force serves to bring first one, then the rest of the family into recovery. Continued, unresolved grief, results in the alcoholism being transmitted across and down the generations until the grief is resolved, and a family member leads the family into healing as described above.

Breaking the intergenerational cycle of alcoholism.

The intergenerational cycle of alcoholism can be broken by any member of the family. This happens in a number of different ways. It might be that an alcoholic decides that s/he is “sick and tired of being sick and tired,” or a Concerned Other member of the family decides, “I’m not going to let this disease take any more members of my family,” or a mother determines that she

is not going to allow her sons to suffer as their father and grandfather did. The family members concerned are not aware of the underlying factors of resolved or unresolved grief, but are acting out of their commitment and Motivation to Change.

Completing the transitional task for “Peace of Mind.”

As people approach vulnerable times in their lives, either through aging, illness, or trauma, and are reminded of their mortality, they start to focus on what they want to accomplish before they die. To quote an elderly patient, “ I want peace of mind, heart and soul before leaving this earth and facing my maker. I want to see my sons in recovery and know that my grandchildren will not suffer as alcoholics like my husband and my sons.” For many, it might mean completing a life cycle transition such as leaving home, giving a daughter permission to marry or have a child, or completing unresolved grief.

Getting a loved one back.

Have you ever asked a family member who came to you for help related to an alcoholic to describe what the alcoholic loved one was like before the alcohol and/or drug use started? Have you ever had family members say to you, “It feels like I have lost my daughter,” or “That is not my father anymore; he was never like that before the drinking got worse?” What each family member will describe is the memory of their loved one’s functioning before alcoholism, and how the individual changed over time as the process of addiction became more and more intrusive, eventually changing thought patterns, attitudes and behaviors. Whether conscious or not, the family wants their alcoholic member “back the way s/he was.” This longing is a powerful motivator for change and a powerful motivator for the family to be interested in “family recovery.” Viewed this way, it is no longer an individual problem. It is a family problem and family recovery becomes the goal.

Preventing more loss.

Families are acutely aware of the risk of losing their loved one through risky behavior and this acts as a powerful element in Family Motivation to Change. The intense connectedness of family members that starts at the time of the first family member becoming alcoholic is an indicator of the life cycle stage at which the original stress precipitated the transitional conflict where the family became “stuck.” This “stuckness” prevents further loss by holding family members close together until the grieving is done as described above in section 2(a). Family connectedness is also the key dynamic that mobilizes family members to serve as effective “Family Links” allowing clinicians to “coach” them and their alcoholic loved ones to enter treatment and continue in recovery. This is in effect, “Family Motivation to Change” in action and is essential in the achievement of long-term commitment to growth and sustained change.

Application of Family Motivation to Change to the

Pre-contemplation and Contemplation Stages of Change and on to Action

Engaging alcoholics and drug addicts is a major challenge to the addictions treatment field: Less than 10% of addicted individuals ever get into treatment (Kessler et al., 1994). ARISE is a 3-Level method designed to use the motivation of family members to get a resistant individual with a drinking problem started in treatment. It is designed to maximize the efforts of the family (defined in the ARISE model as those members in the natural support system that are identified by the “First Caller”) while minimizing the time and effort of the professional. The guiding principle is to stop at the first level that works. Level 1 uses motivational techniques designed specifically for telephone coaching, but they can also be applied to face-to-face sessions. We help the “First Caller” establish a basis of hope, identify whom to invite to the initial intervention meeting, design a strategy to mobilize the group, teach techniques to successfully invite the alcoholic to the first meeting, and get a commitment from all invited individuals to attend the initial meeting regardless of whether or not the alcoholic attends. Level 2 follows, if treatment

does not start during Level 1. Typically, in Level 2, between two to five face-to-face sessions are held, with or without the alcoholic present, to mobilize the intervention network in developing motivational strategies to attain the goal of treatment engagement. Very few families (less than 2%) need to proceed to Level 3. In Level 3, family and friends set limits and consequences for the alcoholic in a loving and supportive way. By the time the intervention network gets to this point, the alcoholic has been given and has refused many opportunities to enter treatment. Because the alcoholic has been invited to each of the intervention network meetings, this final limit setting approach is a natural consequence, does not come as a surprise, and is often almost welcomed.

A recent trial of the ARISE Intervention showed that 83% of severely addicted alcoholics and substance abusers enrolled in treatment or attended self-help meetings following the intervention (Landau et al., 2004). Half of those who entered treatment did so within 1 week of the initial call from a concerned family member or friend, and 84% did so within 3 weeks. Preferred substance of abuse did not have any impact on engagement rate, nor on the level of the intervention at which engagement occurred. The engagement rate did not differ across demographic variables such as age, gender, or race. Finally, the study showed, professional therapists spent an average of less than an hour and a half coaching concerned friends and family members to mobilize their networks to motivate addicted subjects to enter treatment. Before it can be claimed with more certainty that the engagement numbers are reliable, replication by other investigators would be desirable.

The First Call

In the Pre-contemplation and Contemplation Stages of Change, the individual with a drinking problem is either unable or unwilling to see the problem and initiate a commitment to change. The ARISE method encourages clinicians to take a phone call from a concerned “First Caller”

who is asking for help to get a resistant loved one into treatment. This initial request for help may also be done in a face-to-face interview. The ARISE method has a “First Call” protocol and specific coaching techniques that help focus and mobilize the “First Caller” into action (Garrett and Landau, 1999). The “First Caller” is coached as a “Family Link” to understand that: (a) s/he has done the right thing to reach out for help; (b) there is a method that has proven successful at getting resistant alcoholics into treatment; (c) it is important to mobilize as many family members and Concerned Others as possible to meet and focus on getting the alcoholic into treatment; (d) the process of an Invitational Intervention is done with love and respect, and (e) s/he no longer has to deal with the alcoholic one-on-one. There are times when it is appropriate for another person to join with the “First Caller” so the two individuals become “Co-Family Links.” For instance, if a “First Caller” were a sibling of an alcoholic, it might be beneficial if the partner of the alcoholic became actively involved as a “Co-Family Link.” An initial meeting is set up and the “First Caller” is coached on how to invite the alcoholic to that first meeting. There is no need for the alcoholic to sign a Release of Information form in order to have the initial meeting because this individual is not a client in treatment at the point of the “First Call” and at the time of the initial meeting. Contrary to what most clinicians believe, our research shows that 55% of the time the alcoholic shows up for the first meeting and by the end of 3-5 meetings, 83% of alcoholics have entered treatment (Landau et al., 2004).

These intervention meetings build on Family Motivation to Change and exert pressure on the unmotivated alcoholic (in the Pre-contemplation or Contemplation Stage of Change) to enter treatment. The power and strength of the family to provide motivation and support for the resistant alcoholic is unparalleled. No one else in the alcoholic’s life has such a vested interest in, and long-term commitment to, his/her well-being. The statement of that love, concern, interest and support to make changes coming from a group of committed family and friends is a powerful

motivator to help the unmotivated alcoholic move from Pre-contemplation to Contemplation and into treatment. Ongoing intervention network meetings, taking place after the alcoholic has entered treatment, result in a continuity of accountability with the alcoholic for continuing the difficult work required once treatment has begun. Research has demonstrated that there is a correlation between family involvement and longer term retention in treatment. The longer the time spent in treatment the better the outcome. (Conner et al., 1998; Stanton & Shadish, 1997).

Case Example

The authors are currently consulting in Kosova¹ to assist in the design and implementation of the Addiction Education, Resource and Tertiary Treatment Center in Pristina, Kosova, and the development of country-wide addiction services for Kosova—the first addiction treatment system in that country. The following case example demonstrates Family Motivation to Change in a cross-cultural context. Many of the cases coming into the Addictions Treatment Center are related to trauma and loss associated with the war and ethnic cleansing. Because there is little inter-generational history of alcoholism in the Kosovar families, since the predominant culture is secular Islam, the situation presents a unique opportunity to witness how families get off track and how alcoholism develops as an adaptation to major trauma and loss, before being transmitted into future generations. The following case example demonstrates this process.

Sanja is a 17-year-old female living with her widowed 46-year-old father, Jusuf. Sanja is the youngest of 3 children and was 11 years old when the war broke out in Kosova. Both parents were college educated. Her father worked as an engineer for an electrical plant and her mother was an elementary school teacher. The family valued

2. Kosova Ministry of Health and European Agency for Reconstruction (EAR): Establishment of an Addiction Education, Resource and Tertiary Treatment Center in Pristina, Kosova, and Country-Wide Addiction Services for Kosova.

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education and placed a high expectation on completing college. The family lived in Prishtina, the capital of Kosova.

When the war broke out, the electrical power plant in which Sanja's father worked was destroyed. Sanja's mother was taken from their home and was later found dead. Jusuf went into a serious depression after the death of his wife and continues to experience problems with depression, including an inability to work. Up to the age of 15, Sanja was described as a talented student with a keen interest in mathematics and chemistry. Sanja began to exhibit acting out behaviors that included: skipping school, not coming home at night, sexual risk-taking, not doing homework, defiance towards her father, mood changes and a change in her peer group to older youths known to be heavy drinkers and drug users. Jusuf could not handle his daughter's defiant behavior and the result was increased arguing and fighting between them.

Sanja was hospitalized overnight for symptoms that resembled a drug overdose, but she vehemently denied any drug use at the time of this incident. Sanja continued to exhibit out of control behaviors, consistently protesting that she did not drink alcohol or use drugs. Jusuf called the Addictions Treatment Center to find out what he could do to get help for his daughter. He was coached, using ARISE protocols, to approach his daughter, with love rather than threats or anger, about his growing concern for her well-being. He let her know that he would not tolerate her continued acting out and that he had set up an appointment at a treatment facility and would like her to accompany him, but that he would be going to the session regardless of whether or not she decided to attend. (Jusuf applied the driving force of Family Motivation to Change to get his resistant daughter Sanja started in treatment in an effort to get his beloved daughter back and to prevent further loss.)

In the first meeting, attended by Jusuf and his daughter Sanja, the genogram and timeline revealed that Jusuf and Sanja had suffered multiple losses. Not only had Jusuf lost his wife, and Sanja her mother, but Jusuf's mother (Sanja's grandmother— who had moved in with him to help with Sanja), had died as well the following year. Sanja had, therefore, lost two key women in her life within one year. She had also witnessed her father going into a serious depression because of their deaths. Sanja was strongly denying any alcohol or drug use, in spite of a prior hospitalization for a suspected overdose. When Sanja was asked if she worried about her father she softened, starting to cry and told us the history of his depression and how much she constantly worried about him. It was clear that she understood the impact of loss on his functioning.

From a family life cycle point of view, it is clear that Sanja was caught in a dilemma regarding her successfully leaving home. Even though her leaving would be natural and age appropriate, there was a level at which she realized that her father would experience yet another loss because she was all he had left. Her leaving home would likely result in increasing her father's depression. How could she bring harm to someone she loved so much? Not being able to verbalize those thoughts and feelings, even to herself, Sanja started acting out by using alcohol and drugs. This created tension between her and her father, and he kicked her out of their home. Sanja's dilemma about leaving her father and causing more loss in his life was resolved.

Once the clinician shared her perception of the situation, Sanja admitted to her alcohol and drug use, and even though she did not fully understand the impact of her actions, she was able to state, "I was hoping that he would end up hating me and would be happy to see me out of the house." After Sanja agreed to stop her drug and alcohol use (moving from Pre-contemplation into Action), we proceeded to: (a) help Jusuf see

how much Sanja loved him; (b) encourage Sanja to see that she did not have to sacrifice herself in order to leave home successfully; (c) ensure that Jusuf received treatment for depression; (d) work with father and daughter to address the “normal” loss of a child leaving home, and, at the same time, (e) plan for supporting a continued family life-cycle appropriate relationship between the two.

This adaptive behavior by Sanja was designed to protect her father from experiencing another loss and increased depression, and also to take his mind off the multiple losses in the family and his unresolved grief. If unaddressed, one might project how this “adaptive” behavior could have resulted in her “pseudo-individuation,” and the development of alcoholism with the unresolved losses carrying over into the next and future generations. If Jusuf were to die before these issues were resolved and while she was still out of the house and using alcohol and drugs, Sanja would likely feel guilty that her father had died alone and grieving. Her guilt would be increased because of her not being there for him when he really needed her, and for having made him suffer yet another loss. This lack of resolution of the increasing losses might also result in her increased alcohol and drug use at this time.

Conclusion: Practical Application

and Future Implications for Treatment and Treatment Outcome

In conclusion, Family Motivation to Change is essentially the driving force in families that activates resilience and moves them towards health. During times of adversity, loss and trauma, members of a family may become symptomatic, but the family as a whole retains the capacity to heal. We believe that both families and professionals can tap into this resource by trusting in the inherent competence and resilience of families to overcome the despair, shame and guilt of the alcoholic process and access Family Motivation to Change. This driving force can be harnessed to mobilize their support system to motivate alcoholic loved ones into treatment. In fact, we

believe that Family Motivation to Change is the primary factor that frees the alcoholic to move from Pre-contemplation into Contemplation and then into Action.

ARISE (A Relational Intervention Sequence for Engagement) is one of the practical methods that applies Family Motivation to Change to guide and coach families into successfully getting a resistant alcoholic loved one into treatment. Its unusual rate of success can only be attributed to the initiative, dedication, caring, concern and insight of the family members and concerned others in the support systems involved in this Invitational Intervention method.

There is considerable evidence that involvement of families in alcohol treatment has a positive impact on treatment retention (Steinglass, 1987; O'Farrell, 1992; O'Farrell & Fals-Stewart, 1999; Carroll, 1997; Loney, Garrett, & Banks, 1997). In addition, several studies point to improved treatment outcomes with higher treatment retention rates (Stark, Campbell & Brinkerhoff, 1990; Stark, 1992). It might therefore seem reasonable to hypothesize that applying Family Motivation to Change in order to maximize family involvement from the very beginning of the treatment engagement process might well improve treatment outcome and long-term recovery.

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